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RESERVE ROLES IN JOINT MEDICAL READINESS

by

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Preface

The readiness of the medical community and the roles the Reserve components fulfill have been developing areas of interest since my entry into the Air Force in 1977. Over the years, I have observed the emphasis placed on readiness evolve from periodic training of a few selected “mobility” personnel within the facility, to monthly readiness days for all assigned personnel. Deployments, once considered potential only in war, have become commonplace for the military medical personnel. Concurrently, utilization of the Reserve Components (RC) has transformed from mobilization as wartime contingency assets to forward deployed in ongoing international operations. This successful employment of reserve medical personnel in other than war actions highlights the possibilities for expanding the RC roles.

This paper will look at the current responsibilities of the medical reserve component in all services, with a focus on the potential for future roles. Recruitment and retention, along with expanding training opportunities through joint usage of the services’ training sites, and incorporating an AC/RC team approach, will be addressed in relation to more effective utilization of the RC. While the core of RC roles is surge capability during conflict, opportune peacetime medical readiness roles will be discussed. It is not the intent of this study to address the accessibility of the RC, or to discuss mobilization or recall authority, although these subjects merit further research.

Completion of this work would not have been possible without the knowledge of numerous individuals contacted for information. Their patience and guidance was invaluable to developing an understanding of the various services reserve components. The inspiration for the topic, Col Robert Ferguson of the USAF Medical Readiness Division in Washington, DC, was a constant source of expertise and direction for key contacts. My classmates at Air War College provided vital insight into their services' cultures. Finally, a special thanks goes to my advisor, Col Miles Baldwin, for his expertise in jointness; and to my two technical advisors, Col James Gibbar, USAFR, and Lt Col (Dr) William Germann.

Abstract

The Reserve Components, as an integral part of the Total Force, must match capabilities and roles to proposed medical readiness re-engineering. The two reasons for this: (1) the services are downsizing and streamlining the medical corps, reducing the number of personnel available for deployments, and (2) the reserve medical personnel can provide the expansion and surge capabilities in specialized skills necessary for wartime operations. Training and recruitment need to be examined to meet the requirements resulting from Medical Readiness Re-engineering.

Chapter 1

Total Force Joint Medical Readiness

The nature of modern warfare demands that we fight as a joint team. This was important yesterday, it is essential today, and it will become even more imperative tomorrow.

— General John M. Shalikashvili

A decade ago, the world was dominated by two superpowers, a group of significant but lesser military powers, and numerous second and third world countries. International politics were conducted with a cautious eye on the response of the United States and the Soviet Union. Military planning focused on global war, with Europe as the most likely scene of action. The United States concentrated on large scale, protracted conflict, with assets prepositioned in allied countries of Europe. Reserve personnel trained for mobilization roles, to supplement and backfill the active duty forces in war. Limited emphasis was placed on active/reserve or interservice training.

The demise of the Soviet Union as a entity and collapse of communism in Eastern Europe permanently altered international relations. Germany reunified into a democracy, while the former Soviet Union and Eastern Europe dissolved into independent, politically unstable countries. Animosities long suppressed under communism surfaced, creating tensions in places unheard of by Americans ten years ago. The United States became the

world's sole superpower, shifting the military's focus from deterrence of global war to numerous limited regional conflicts.

American interests have turned towards resolving domestic issues, and congressional budgeting reflects the will of the people. Yet the American public continues to expect the Armed Forces to be successful in any engagements. Faced with declining financial resources, the services have right-sized and reorganized to meet the unpredictable future environment. Drawing down has promoted drawing together, evaluating capabilities and consolidating resources to form a smaller, more efficient military. An increasing emphasis has been placed on the utilization of the Reserve Components (RC), to meet mission requirements in daily and contingency operations.

The decline of the threat of global war has not decrease the medical services' commitments throughout the world. Engagement in operations other than war such as peacekeeping, peacemaking, and humanitarian missions have resulted in more frequent deployments of medical manpower. The ongoing nature of these operations has led to deployment rotations between the services, with the Reserve Components sharing the manning responsibilities. Although most are termed peace operations, the volatility of the players increases the potential for escalation into conflict, with resulting combat injuries. The medical services must maintain a level of readiness to adapt to the unpredictability of any operation. This can best be accomplished by optimum utilization of the Total Force of all of the medical services.

Total Force

The concept of Total Force began in 1970, when Secretary Melvin R. Laird announced the Reserves would be the initial source of active duty augmentation during crisis, instead of the draft. His successor, James R. Schlesinger, made Total Force a policy in 1973, integrating the active duty, guard and reserve forces to create an analogous whole. As partners, the reserve components were expected to meet the readiness standards of the active duty units.¹ New missions were gradually acquired by the RC as the size of the active duty force decreased, and medical personnel began routinely deploying worldwide on humanitarian missions.² By the end of Fiscal Year 1995, the RC contribution ranged from 24% to 87% of the total medical assets for the various services.³

Integration of the RC into daily operations has become increasingly important in reducing the operating tempo for the active components. Utilization of the RC in executing the national strategy can provide significant savings and generate public goodwill.⁴ Medical personnel are currently deployed, either concurrently or rotating with the active duty units in Bosnia, Croatia, and locations in South America.⁵

Joint

The Goldwater-Nichols Defense Reorganization Act of 1986 directed the services to work together to implement a smaller, more effective military. Success in Operations Just Cause, Desert Storm and Provide Comfort are used as examples of the effectiveness of integrating Service capabilities. Jointness and improved interoperability are achieved through the “seamless integration of Service capabilities.”⁶

The roles the medical services fulfill within the respective military services are basically similar, i.e. providing the highest quality health care to the military personnel, retirees, and their families. Unity of focus, integrating resources, and ensuring interoperability of care provided along the continuum of treatment improves effectiveness, promoting optimum outcomes. Each medical service retains the capabilities unique to their operational domain, bringing specialized qualities into the seamless flow of medical care.

Medical Readiness

Medical Readiness is defined as “the ability to mobilize, deploy, and sustain medical services for any operation requiring medical services; to maintain and project the continuum to healthcare resources required to provide for the health of the force; and to operate in conjunction with beneficiary healthcare.”⁷ Radical changes in the international security environment have changed the focus of medical readiness, expanding from a concentration on wartime operations to include peacetime contingencies and low-intensity conflicts.

Central to medical readiness is preparation and training, as well as providing care to the operational forces wherever and whenever necessary. It is delivering healthcare to maintain the wellness of the forces, prevent casualties from disease and injuries unrelated to battle, and implementing early trauma treatment to combat casualties.

In the Medical Program Guidance, FY 1998-2003, Dr. Stephan C. Joseph outlines readiness as a core area of the Defense Health Program. The uniqueness of military medicine demands preparation beyond the typical healthcare skills. Environmental

extremes, potential exposure to chemical, biological, and nuclear weapons, treating injuries from high velocity projectiles or thermal injuries are challenges for the military medical provider.⁸ The operational and tactical considerations in the combat environment may hinder the provision of care.⁹

The effectiveness of the smaller, more agile combatant forces depends on the contribution of every member. A healthy, fit force is needed to contend with the various environmental challenges the military is now facing. In response to this requirement, military medicine is redirecting from a reactive emphasis on treatment of illness and injury, to proactive promotion of health and preventive care. While superior technology and advanced weapon systems have made the United States military premier in the world, it is powerless without the most vital element—effective personnel. Maintaining this force capability is the responsibility of the joint medical services. The dividing lines between the medical and operational communities are blurring, as military medicine moves to a force enhancement role.

Total Force Joint Medical Readiness is the formation of a cohesive partnership of the services' medical forces, utilizing the Active and Reserve Components, to form a contingency force that can mobilize rapidly and operate anywhere in the world. It is integrating capabilities into a cohesive health delivery system that provides top quality care to the Armed Forces. The contributions of each of the services' total force assets is vital to the success of the mission.

Notes

¹History of the United States Air Force Reserve (Air Force Reserve History Office, 1996), 6.

²Ibid., 6.

Notes

³Office of the Secretary of Defense, *Reserve Component Programs Fiscal 1995: The Annual Report of the Reserve Forces Policy Board* (Washington, DC: Government Printing Office, 1996), 12-18.

⁴Department of Defense, *Directions for Defense: Report of the Commission on Roles and Missions of the Armed Forces* (Washington, DC: Government Printing Office, 1995), 2-23.

⁵Reserve Component Programs, 64.

⁶Joint Vision 2010, 8.

⁷Lt Paul Bledsoe, "Total Health Care Support Medical Readiness Requirements," *Army Medical Department Journal*, Sept/Oct 1996, n.p.; on-line, Internet, 12 December 1996, available from <http://www.acs.amedd.army.mil/das/J9652.HTM>

⁸Department of Defense, *Medical Program Guidance, FY 1998-2003* (Washington, DC: Office of Assistant Secretary of Defense (HA), 14 February 1996).

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Chapter 2

Reserve Components

The success of our medical readiness posture depends on how effective the Active and Reserve Components can work together as a team using all available resources. This effort will serve as a force multiplier.

—Mirror Force Strategic Plan 1996

The Reserve Components have become an integral part of the Total Force medical services. The past role of “assisting” the Active Components (AC) has evolved into “permitting” the Total Force Military Service to accomplish an increasing span of operational missions.¹

The RC medical manpower contribution varies for the different military services. Care provided by each service, while conceptually similar, is unique to the environment the service dominates. The Army RC medical personnel are focusing on rapid mobility, forward presence, and are designing smaller ground units. The Air Force RC are the wings of the medical service, providing aeromedical evacuation in daily operations, as well as inpatient and outpatient care in medical treatment facilities. Navy RC personnel are trained for shipboard, aviation, and Marine operational medical support.

There are five organizations in the medical Reserve Components: the Army Reserve, the Army National Guard, the Navy Reserve, the Air Force Reserve, and the Air National

Guard. The Marines do not have medical care providers in the Reserve Component, receiving their support from the Navy medical personnel.

Army Medical Reserve

The Army Medical Department is currently redesigning the medical force to meet the characteristics for Force XXI: doctrinal flexibility, strategic mobility, tailoring ability and modularity, joint and multinational connectivity, and the versatility to function in war and operations other than war.² Medical systems are being tailored to support the rapid operational tempo and diversity of operations the Force XXI Army will encounter. The four types of hospitals currently used in combat support, ranging from the 60-bed mobile army surgical hospitals to the 400-bed field surgical hospitals, are being redesigned into 248-bed combat support field hospitals. Each will have an 84-bed functionally capable unit that can be deployed separately for prepositioning or to be echeloned into the theater for early operations.³

The functional structure of the Army medical service is being reorganized, combining detachments to form new units, increasing capabilities while decreasing duplication of command and control.

The Reserve Components are integral in the reorganization. Unit functions are being reviewed, missions are being realigned, and command and control is being relocated to facilitate better operational capability.

The Reserve Component of the Army is comprised of the Army National Guard (ARNG) and the Army Reserve. The ARNG is a unit program, while the Reserve has

both units and Individual Mobilization Augmentees (IMA) to fill vacancies in organizations as needed.

Manpower in the Army RC is critical to fulfilling the wartime mission. Seventy percent of the Army medical personnel strength and sixty percent of the air ambulance aircraft are in the Reserve Component. See Table 1.

Table 1. Army Reserve Medical Personnel

	National Guard		Army Reserve		
	Authorized	Assigned	Authorized	Assigned Unit	IMA
Medical Corps	1656	864	2667	1618	431
Dental Corps	614	259	895	582	62
PA	706	332	476	288	47
Nurse Corps	1452	1013	6317	6194	866
Medical Svc	1372	1114	786	490	199
Vet Corps	49	28	17	20	5

Source: Army Reserve Personnel Center data

Navy Medical Reserve

The Naval Reserve (USNR) includes physicians, nurses, dentists, medical corpsmen, dental corpsmen, and physician assistants. They are deployable to the AC/RC assets of ships, Seabee units, overseas medical treatment facilities (MTF), CONUS MTFs, Marine units, and with the aviation squadrons.

There are five programs in the Selected Reserve for medical personnel. Each has distinct operational environments, and vary in size from less than 100 people to over 1000 person units.

1) Fleet Hospital Program (Program 46)—the RC provide 1000 person packages to staff four of the ten Fleet hospitals. These are 500 bed self sustained field hospitals, located in the combat and rear zones.

2) Surface Medical Program (Program 32)—the primary function of the selected reserve in the Surface Medical Program is to backfill CONUS MTFs on deployment of the active component personnel. These facilities would receive casualties evacuated from the theater of operations for long term recovery and rehabilitative care. The personnel in Program 32 are also the primary source for manpower replacement in the theater.

3) Aviation Medical Program (Program 5)—this program supports the naval air reserve operations with trained and ready flight surgeons and technicians. Program 5 also support the active duty flight operations.

4) Reserve Naval Combat Force (Program 7)—these units provide medical and dental personnel to support the Seabee units, deploying worldwide.

5) Fleet Medical Force (Program 9)—The Selected Reserve personnel deploy with the Reserve 4th Marine Air Wing, providing care to three infantry regiments, one artillery regiment, and a Force Service Support group. The selected Reserve personnel support Marine operations in the field, wearing Marine uniforms, but like their active duty counterparts, are Navy personnel.⁴

The majority of the reserve personnel are in Programs 46 and 32, working in MTFs. The reserves currently have unfilled billets in all corps. See Figure 2.

Table 2. Navy Medical Reserve Personnel

	Authorized	On Board
Medical Corps	1750	1293
Dental Corps	576	377
Medical Service Corps	806	653
Nurse Corps	2923	2051
Enlisted	8964	5471

Source: NAVRESFOR. Interview by author, Montgomery/Louisiana. Telephone interview. Dec 2, 1996.

Air Force Medical Reserve

The two portions of the RC in the Air Force are the Air National Guard (ANG) and the Air Force Reserve (USAFR). The ANG is a unit program, with both flying and ground organizations. The USAFR, in addition to the unit program, has a variety of individual programs to provide specialized personnel to fill vacancies as needed.

The RC is the flying portion of the Air Force medical service, providing 87% of the Aeromedical Evacuation aircrews. These flight surgeons, nurses and technicians care for patients transported both intertheater and intratheater.

The missions of the non-flying units are to supplement manning for the Air Transportable Hospitals in the field, to provide backfill personnel for the MTFs in CONUS and overseas, and a source of specialized individuals to supplement medical personnel packages as needed.

The authorized and assigned personnel levels are listed in Table 3. Medical (MC), Dental (DC), and enlisted corps are consistently undermanned in all three organizations.

Table 3. Air Force Reserve Medical Personnel

	ANG		USAFR (Unit)		USAFR (Individual)	
	Authorized	Assigned	Authorized	Assigned	Authorized	Assigned
MC	522	439	425	328	299	274
DC	188	165	102	124	104	87
MSC	252	284	429	472	134	142
BSC	367	287	208	185	236	286
Nurse	816	829	1769	1796	679	727
Enlisted	4980	4719	6688	6581	663	600

Source: Air National Guard Readiness Center data. Available at <http://www.ang.af.mil/angrc-sg/recruiti/mnpwr1.htm>

Under the initiative “Medical Readiness Reengineering,” the Air Force Medical Service is reorganizing the deployment structure, incorporating modular Unit Type Codes (UTCs). The RC is vital to the implementation of Air Force Medical Readiness, with over 60% of the reengineered UTCs assigned to the Reserve Components.⁵

Notes

¹Office of the Secretary of Defense, *Reserve Component Programs Fiscal 1995: The Annual Report of the Reserve Forces Policy Board* (Washington, DC: Government Printing Office, 1996), xxi.

²LTC Joseph M. Harmon III, “Medical Organizational Design and Experimentation for Force XXI,” *Army Medical Department Journal*, July/August 1996, n.p.; on-line, Internet, 12 December 1996, available from <http://www.acs.amedd.army.mil/das/J9641.HTM>, quote from TRADOC Pamphlet 525-5.

³Major Ulmont Nanton, “The AMEDD Experience: Medical Reengineering Initiative,” *Army Medical Department Journal*, Sept/October 1996, n.p.; on-line, Internet, 12 December 1996, available from <http://www.acs.amedd.army.mil/das/J9638>.

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⁵*Reengineering Medical Readiness, The Total Force Answer*, 1-2.

Chapter 3

Future Reserve Roles

The RC are an integral part of numerous medical missions. Personnel are deployed worldwide, participating in humanitarian and peace operations with the AC on a daily basis. The strength of the Reserve Components is as a ready source of trained and qualified manpower, to be tapped as needed. By co-locating on active military facilities and sharing resources, the RC can maintain the high productivity on a smaller operating budget.

The roles most suited to the medical RC relate to expansion and surge capabilities, and roles not required in daily peacetime operations. Civilian job conflicts make fulfilling on-going military contingencies difficult to maintain. Through volunteerism, the RC has successfully met these obligations in the past when asked, but it is not the preferred method of operation, or a guaranteed source in wartime.

Source of Specialists

The draw down in the size of the military services has led to a corresponding decrease in the size of the medical services, and a focus on Family Medicine as the primary source of medical care. Medical specialties are being cut from peacetime care, and patients are being referred to local civilian specialists when treatment is required.

While this is a cost efficient mode of operation during peacetime, it is not effective for the deployed unit.

Conflict contingencies require a large number of specialists in critical care, emergency care, surgical suite, and surgical care. An expanding role for the medical RC is being a source of specialists when the active units are unable to man the slots.

Professionals qualified in critical care and surgical suite personnel are in high demand during wartime surges. Yet critical care and operating rooms have become high technology, high cost MTF operations. In a budget conscious environment, these become prime targets for deletion, outsourcing, or consolidation at a few major medical facilities. The personnel soon lose vital skills without the hands-on experience. As units close, manning slots are deleted, and personnel numbers are reduced. The military members can transfer within the facility, move to a new location, or separate from the military. The end result for the facility is a loss of wartime skills. It is not only critical care units and specialty areas being deleted from military MTFs. In a recently announced defense budget proposal, 17 military hospitals are to be downgraded to extended hour clinics, discontinuing inpatient care capabilities.¹

Use of Nurse Practitioners and Physician Assistants

Physicians are primary care providers, and have long been considered essential medical personnel in field hospitals. Their scope of care exceeds that of the nurses and medical technicians/corpsmen. Yet physicians are traditionally difficult to recruit and retain, requiring a re-evaluation of the roles of other care providers.

Two categories of primary care providers, physician assistants (PA) and nurse practitioners (NP), should be considered to supplement medical readiness roles of physicians. In civilian practice, PA's and NP's provide direct outpatient care in various specialties, including emergency medicine, Family medicine, orthopedics, and Adult medicine. Many are qualified as first assistant to the physician in surgery. Job titles reflect only a limited portion of the capabilities of this cadre. These qualities should not be overlooked when considering personnel for wartime missions.

The Army RC has recognized this potential source of qualified personnel. The PA's are utilized at front line stand alone units as the care providers, assisted by medical corpsmen. The advent of telemedicine and digital technology will enhance the ability of these healthcare providers to administer optimal care in the field, while maintaining contact with consulting physicians.

Until recently, nurse practitioners were designated for few wartime missions, primarily to be utilized in CONUS. In October 1996, the Air Force realigned the Unit Training Codes, and the professional physicians extender slots are now divided evenly between NP's and PA's. The roles these providers will fulfill is being studied. One of the reasons behind this change was the scarcity of female providers in the Persian Gulf during Desert Shield/Desert Storm, where 11% of the personnel in theater were female.²

Rapid Response Teams

Responding to the emphasis on rapid mobility and forward presence of the fighting forces, medical care is being designed for initial trauma treatment, stabilization and expeditious transport. The Army and Air Force have developed rapid response combat

casualty teams to provide immediate care. Navy teams are utilized in peacetime and low level conflict to augment existing MTFs or deployed units. The RC can provide the specialized personnel to man and expand these teams during conflicts.

The Army's forward surgical teams are designed to administer advanced trauma management. The 20-member teams, with two operating tables and sufficient supplies to care for 30 critically wounded patients, can provide resuscitative surgery or maintain the lives of combat casualties until they can be evacuated to more comprehensive care facilities.³

The Air Force's Aeromedical Evacuation Critical Care Transport Teams have participated in operations in Haiti, Bosnia, and the Khobar Towers bombing.⁴ These three-person teams are organized to enhance the aeromedical evacuation of stabilized and shock treated patients. Each member is intensive care qualified, and knowledgeable in the treatment of burn patients. The potential to add a Respiratory Therapist or technician is being explored.⁵ It is not the role of the teams to provide initial stabilization or forward surgical care. The team provides the capability to transport critically ill or injured patients rapidly, with continued monitoring and intervention in the air.⁶ Members of the teams are required to be both critical care qualified and air evacuation qualified. While some AC teams should be developed for early conflict response, the majority of the teams will be RC personnel. This is a wartime surge requirement well suited to the Reserve Components.

There are cultural conflicts in developing naval combat casualty teams. Navy medical assets are oriented for hospital-based medicine, not direct support of combat forces. The majority of casualty care is on the hospital ships, with scant facilities on

amphibious ships. Field medicine is considered a less attractive career option for medical officers in the Naval forces. Few Navy physicians or nurses have indoctrination in field training or are fully familiarized with the operational billets.⁷

The Navy's Mobile Medical Augmentation Readiness Teams (MMARTs) provide medical augmentation to deployed units or MTFs during peacetime contingencies and low-intensity conflicts. Although designed primarily to support peacetime, humanitarian and preventive medicine endeavors, the team membership is similar to the rapid response combat surgical teams.

Support for the MMARTs has been mixed, since deployments impact on the MTF's main focus, beneficiary care. The deployment of a surgical team can shut down an operating room, and remaining personnel incur extra duties to compensate for the decreased manning. Training is essential to maintaining a cohesive, smooth functioning team, but the time spent in training can impact the MTF's ability to meet the daily mission.⁸

While peacetime MMART membership for most Navy RC members is difficult, there is potential for utilizing qualified specialty personnel as MTF backfill during MMART deployments. By scheduling reserve units for their active duty tours during the month the facility's MMART teams are on alert, the MTF's daily requirements can be met. Both the AC and the RC benefit from this coordinated effort. The reserve members obtain experience in performing military medicine, while the MMART members are available for alert, or for training when not deployed. As a wartime mission, there is potential for an AC/RC mix of personnel fulfilling rapid response team roles, should this be developed as a Navy role.

Evacuation Transport

The diversity of operating locations and the rapid operational tempo military forces are encountering has lead to a redefining of medical service roles. Emphasis is being placed on treating patients earlier, in forward locations, providing shock treatment and stabilization for transport to comprehensive care facilities.

Evacuation of casualties is an increasing concern for medical and field commanders. Air evacuation has been the preferred method in past conflicts, but ground and sea evacuation may be more appropriate in future operation scenarios. In previous conflicts, ground evacuation has been sourced by the individual services to support their own deployed medical personnel. There is no integrated casualty evacuation system.⁹

Air evacuation has primarily been the responsibility of the Air Force, with 87% of the personnel assets provided by the RC. There is an increasing emphasis to augment the crews with the Critical Care Transport teams.¹⁰ As stated earlier, the RC are well suited to fill the roles as Critical Care Transport Team members and as air crew members. This is not a new role for the Air Force RC; it is an ongoing and expanding role.

The Army has developed the Enhanced Armored Ambulance and the UA60Q Air Ambulance to improve mobility, survivability, and medical treatment capabilities.¹¹ Evacuation is a portion of combat and combat service support in forward units. The Army Reserve Component contributes 87% of the medical personnel and 60% of the air ambulance aircraft. Recent force restructuring added 19 Air Ambulance companies to the ARNG, by converting combat aviation units into aeromedical units.¹²

There are no assets currently identified for secondary roles of sea transport of injured personnel between theaters. Ship to ship and ship to shore evacuation utilizes boats and

helicopter assets available in the area at the time. There are no designated ambulance ships.¹³

Sea transport issues are being reviewed in the Medical Readiness Strategic Plan, Action item 21. When developed, this is a role well suited for the RC. Sea transport is not a day to day mission, but becomes significant during conflict. The Naval RC can organize units to prepare for this combat mission.

The RC can be effectively employed in expansion and surge capability roles. Specialized expertise, evacuation and wartime rapid response medical teams are functions not required for large scale use on a daily basis in peacetime, but become essential in conflicts. The RC can provide the critical manning for these roles.

Notes

¹Hawkins, B. Denise, *Deep Cuts May Hit 1-2 Health Programs*, Air Force Times, January 27, 1996, 3.

²USAF Medical Readiness Division, *Reengineering Medical Readiness: The Total Force Answer*.

³Major Ulmont Nanton, "The AMEDD Experience: Medical Reengineering Initiative," *Army Medical Department Journal*, Sept/October 1996, n.p.; on-line, Internet, 12 December 1996, available from <http://www.acs.amedd.army.mil/das/J9638>.

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⁹Department of Defense, *Medical Readiness Strategic Plan: 1995-2001* (Washington, DC: Assistant Secretary of Defense (HA), 20 March 1995), 40.

¹⁰Chapman, 36.

¹¹LTC Joseph M. Harmon III, "Medical Organizational Design and Experimentation for Force XXI," *Army Medical Department Journal*, July/August 1996, n.p.; on-line,

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¹³Medical Readiness Strategic Plan, 34.

Chapter 4

Training

We will ensure a doctrinally sound, operationally integrated, joint medical force capable of successfully meeting health service demands throughout the continuum of military operations.

—MHSS Strategic Planning

Two areas of ongoing concern for the medical RC are training and maintaining the proficiency of their people in the limited available inactive and active duty time; and recruiting/retaining the quality personnel. Upgrade and sustainment training is vital to ensure that all members are qualified for the wartime readiness missions. Opportunity to practice the necessary skills may not be available in their civilian practice, or the civilian occupation does not match their military obligations.

A growing source of frustration for the Reserve Components is the increasing number of education and training requirements to be completed during the monthly inactive duty tours and the annual tour. Expanded missions, requirements for advanced certifications and training, while maintaining currency in sustainment training, are overloading the time together as a unit. To resolve this time dilemma, steps in the right direction are being taken in ongoing reviews of training requirements. Non-mission essential directives are being reduced or eliminated, and the focus is being placed on essential mobilization competencies.

Training for medical readiness needs to be reviewed, considering all components need to maximize utilization of resources. The concept of designing training for the active components, then adjusting to create RC training, is not adequate. The basic mission, providing expedient quality care, is the common goal of all branches of military medicine. Joint training promotes understanding of the similarities and strengths of the sister services, building a homogeneous relationship in peacetime that promotes cooperation during real world operations.

The number of anticipated casualties in a given scenario will determine personnel requirements, not whether the staff will be active or reserve component medical personnel. Staffing becomes a function of when casualties are expected to occur. Active units can generally be deployed earlier than reserve units, so the AC would be utilized for large number of casualties occurring early in the conflict. Requirements for care of casualties occurring later in the conflict can be met by the RC.¹

The quality of training can be improved by implementing a program similar to the Reserve Associate program now used by Air Force operational units. The Associate Program pairs RC and AC units, sharing a single set of aircraft, while providing trained crews and maintenance personnel for approximately 300 active duty aircraft and space operations. The unit members work together, building a cohesiveness and understanding, and all members benefit from the diversity of knowledge brought to the union.

An integrated medical readiness training program can be developed between RC and AC units with similar mission requirements. Training would be conducted together, using the same resources, and taught by a cadre of RC and AC instructors. While learning together, utilization of resources would be enhanced, and both units would benefit from

the diversity of knowledge and experience brought by the individual members. Better working relationships and confidence in the abilities of their counterparts would be the outcome.

Peacetime and humanitarian operations have exposed an increasing number of both AC and RC members to deployments in field conditions. These personnel are a valuable resource to utilize when organizing medical readiness training. Their insights on the realities, problems encountered, and lessons learned will enhance the effectiveness of the training.

Training schedules need to be flexible using the associate unit concept. The mindset of training only occurring on designated days or at designated sites would be obsolete. Courses would be scheduled on weekdays and weekends, to accommodate all personnel. Clinic and administrative staff in the MTF, who normally work a five day-shift week, would alternate between weekend and weekday courses. This would reduce the need to close clinics for training, thus decreasing a source of frustration and complaints from health care recipients. For the RC members, scheduling conflicts with civilian jobs would decline, having the option to attend on days off during the week.

The greatest advantage to pairing active duty and reserve units is the joint training. Counterparts would be receiving the same education, assuring continuity of care during deployment rotations. The cadre of knowledgeable instructors would be expanded, and the number and quality of mobility assets would be enhanced. The result would be cohesive readiness teams, capable of deployment anywhere in world.

The equipment and procedures of the mobility packages can be incorporated into the active duty daily operations and the reserve unit training days. Dependence on advanced

technology and automated equipment results in an inability to function when the same advantages are not available in the field. Personnel need to familiarize themselves with the equipment used in their operational billets. Blood pressures can be taken using manual cuffs and stethoscopes during ward rounds, and anesthesia equipment from the field hospital can be used in the MTF for non-emergency procedures. Hands-on experience in a low intensity, familiar environment will enhance proficiency, and will avoid the pitfalls of learning “under the gun” in a real world crisis.

Combined AC/RC field training exercises need to be more realistic. Training conducted from 0800 to 1600 hours, lectures in tents, bringing bag lunches in mini-coolers, and going home each night will not prepare the personnel for deployments. When exercises are conducted on the military installation, clinical patients can be seen for routine visits, and minor surgeries/procedures can be performed. Staff should stay in the field at night, and no-notice mass casualty exercises should be conducted.

The purpose of training is to prepare for deployment, learn to live and operate in various environments, and function effectively in assigned roles. When the training does not resemble reality, precious time is wasted without benefit to the units.

Ongoing overseas operations have led to multi-service deployments to the same facilities. It is possible to have an Army field hospital being staffed by Air Force personnel, under the command of an Army Hospital Commander. On the next deployment rotation, personnel from Navy MTFs arrive to replace the Air Force units. Each service has a unique culture, as well as differing equipment, methods and procedures. Exposure to sister medical services needs to occur before deployment to real world locations. This can be accomplished through Joint Medical Readiness Training.

The Joint Medical Readiness Training Center provides the Tri-service Combat Casualty Care Course as field training and mobile training programs. There are twelve medical field training sites (7 Army, 1 Navy, 2 Air Force, 2 Marine) where service specific exercises are currently conducted. The opportunities for joint training could be maximized by including personnel from all of the services into those programs and courses, providing an exchange of training skills and knowledge.²

The medical services can benefit from participation in exercises with the combatant forces. There has been a decreased involvement by medical personnel in unified command exercises and testing of RC call-up for CONUS backfill has been lacking.³ The medical services must remedy these deficiencies by training with the fighting forces, and ensuring recall procedures are effective.

The Total Force must train together, communicate in a common language, and integrate the services' medical systems to reach a goal of joint medical readiness. Historically, there have been problems merging the RC into AC operations, because of lack of adequate training for the RC. This deficit was noted by the General Accounting Office in reviews of the Gulf War, a deficiency that needs to be corrected to prevent future deployment problems.⁴

An Air Force program, known as Mirror Force, is addressing this issue. The objective is to provide the same medical readiness training to all medical personnel, regardless of component, resulting in a medical force where members can be utilized interchangeably in contingencies, performing the same jobs with the same high level of competence. The RC members will "mirror" their AC counterparts capabilities in

medical readiness.⁵ This innovative program merits consideration by all the services for incorporation into AC/RC training programs.

Notes

¹General Accounting Office, *Wartime Medical Care: Personnel Requirements Still Not Resolved* (Washington, DC: General Accounting Office, 1996), 5.

²Department of Defense, *Medical Readiness Strategic Plan: 1995-2001* (Washington, DC: Assistant Secretary of Defense (HA), 20 March 1995), 40.

³*Ibid.*, 40

⁴Suzann Chapman, "The Quest for Medical Readiness," *Air Force Magazine*, November 1995, 35.

⁵*Ibid.*, 36.

Chapter 5

Recruitment and Retention

Medical recruiting and retention is particularly difficult for the reserves. Many of the credentialed officers are private practitioners, with a professional practice dependent on the loyalty of their clients. Leaving the practice for extended periods of time erodes the patient/provider relationship, and the practitioner may lose business. Progress has been made in providing loss of income insurance for periods of deployment, and while this may prove financially helpful, the loss of clientele has a longer term effect on the practice.

Current programs such as student loan programs, the stipend program, loss of income insurance, and flexible participation programs have helped to increase the attractiveness of medical reserve participation. But the Reserves must continue to find methods to recruit qualified personnel.

Medical schools and nursing schools offer opportunities for recruiting qualified candidates. As students, the people have not committed to a practice or a job. Many are in the process of deciding on a specialty area, and are receptive to possibilities for the future. Information on the range of available options and opportunities in military medicine could prove productive in recruiting qualified personnel. Once in practice, the medical provider develops commitments to the clientele, partners, and co-workers/employees that are more difficult to leave, even for short periods of time. By

introducing these students to military medical opportunities, interest can be developed to pursue a Reserve commitment to complement their future civilian practice.

Informal recruiting can be done by any medical RC member. The Reserve Components are the link between the military and civilian communities, with employment in both locations. Co-workers in the civilian facilities can be educated about RC duty, and encouraged to consider possible duty.

The RC member is also employed in the military community, with exposure to active duty members considering separation from their respective services. While it is not the intent of the RC to entice active duty members into the RC, it is a loss of valuable assets to have any member separate from the military. Participation in the RC maintains the expertise and experience in the force, while allowing the individual to pursue a civilian career.

Military medicine offers unique experiences to the practitioners that may not be available in the local civilian sector. The care provider is challenged by the diagnosis and treatment of diseases or injuries not encountered in civilian life. Experiences in various environmental settings, commander and leadership responsibilities, and the operational/tactical considerations of military medicine are unique aspects of military medicine.

Health professionals are highly motivated for self improvement, through knowledge broadening training and continuing education. Military medical centers are on the forefront of technological advances, offering the practitioner challenges not available in private practice or most community hospitals. Field medicine is also becoming more technologically advanced. The Army is currently developing systems of telemedicine and

teleconsultation to improve the initial trauma care in battle. Teleconsultation, using high-resolution still images and full motion video capability, links the medical professionals in forward locations to expert practitioners at facilities with greater resources, allowing complex procedures to be performed earlier in trauma care.

The RC offers a variety of participation options for health professions. The most common, the stereotype “week-end warrior” duty is the Unit Reserve or Guard. The member performs duty one weekend a month and a two week active duty tour once a year. Normally duty is performed as a unit, although exceptions for schedule conflicts can be accommodated. The unit programs offer the opportunity for leadership roles within an organized structure, as well as administrative support.

Other options are the individual programs, which are less time intensive and accommodate flexible scheduling. The member is attached to an active duty unit, and arranges duty time with an active duty supervisor. The member participates a minimum of one day a month, with a two week active duty tour once a year. Duty can be spaced throughout the year, one day a month, or consolidated into any grouping convenient to the individual and unit of attachment. Personnel in critical specialties, primarily operating room and critical care, can earn participation points in lieu of performing duty by attending continuing education courses and professional medical conferences.

Individuals in small private practices have difficulty scheduling reserve duty. Obligations to partners and clients conflict with military responsibilities. The possible loss of clientele during deployments, and potential difficulty rebuilding the practice discourages military reserve participation.

Health Maintenance Organizations (HMOs) are potential locations for recruiting qualified personnel. HMOs are becoming increasingly common in civilian medicine. These organized medical systems employ numerous medical professionals, many in critical care, surgical suites, and the spectrum of medical/surgical specialties. The providers are paid by the HMO, not by the patients.¹ The providers are not dependent on their clients for income, and can return to practice within the system after deployments without significant loss of clientele.

Retaining qualified personnel is as significant as recruiting. Numerous programs have been implemented to retain personnel in critical skills. These incentive programs include special pay for physicians, Selected Reserve Health Care Professional Bonus, and malpractice/tort liability relief in the event of mobilization.²

The newest program, the Ready Reserve Mobilization Income Insurance Program, was designed to protect reservists from economic loss resulting from mobilization. As of January 10th, 1997, there were only 14,600 people signed up, and premiums collected amounted to \$500,000. The pay-out due was about \$72 million, because many of the participants were deployed to Bosnia soon after enrolling in the program.³ Supplemental funding has been requested to correct the initial shortfall, and with new guidelines, this program should soon be on track.

The decision to continue or discontinue Reserve participation involves many factors. Intangibles such as pride, patriotism, and duty to country contribute to retention, as well as the various incentive programs. But negative factors can turn the tables, resulting in loss of qualified personnel. These disincentives must be addressed and removed to improve retention.

Health professionals are motivated for self-improvement, through knowledge broadening education and challenging experiences. Reserve time spent in repetitive tasks, as excess manning, or in training unrelated to wartime skills will diminish both interest and enthusiasm. Duty time needs to be worthwhile and useful. This can be accomplished through training focused on wartime skills, and scheduling duty when the Reservists' skills can be utilized. Known periods of AC deployments, high leave periods, or when personnel shortfalls will occur due to permanent change of station moves are opportune times to schedule active duty tours. Coordination is vital between the RC and AC when military MTFs are used, to ensure duty time is put to use for the greatest benefit of both components.

Another disincentive is the lengthy process of credentialing practitioners. Medical providers are required to be credentialed in their specialty prior to being allowed to administer care. This process can take weeks to complete, while the provider is unable to perform duty. Credentialing is done by each facility; it is not a centralized process. Developing a credentialing system that is quick, efficient and allows for interservice reciprocity would alleviate the frustration of the practitioners.

There are no quick fixes or easy answers to the problems of recruiting and retaining qualified personnel. Early identification of potential candidates, providing intangible and monetary incentives, and creative scheduling of training can contribute to alleviating these difficulties. But there is no substitute for the appeal to the individual's pride, patriotism, and duty to country.

Notes

¹*New Standard Encyclopedia*, 1993 ed., s.v. “Health Maintenance Organizations,” H-101.

²Department of Defense, *Medical Readiness Strategic Plan: 1995-2001* (Washington, DC: Assistant Secretary of Defense (HA), 20 March 1995), 37.

³Lori Wiezorek, *TROA Legislative Update*, n.p.; on-line, Internet, 17 January 1997, available from <http://www.troa.org>

Chapter 6

Conclusions

The military forces are becoming smaller in response to the changing political and economic conditions. Declining budgets have fostered a need for cooperation between the services, to work on joint programs to modernize and remain ready in an unpredictable environment.

Downsizing the force structure has resulted in smaller active duty medical services, yet the operational tempo has continued throughout the world. Reserve Component participation has increased to meet the demand, share in deployment responsibilities, and provide the skilled personnel to offset active duty shortfalls. It has become apparent to both the medical AC and RC in all services the missions cannot be met without working together.

The roles of the medical RC are increasing in size more than in variety. Participation by the RC in peacetime and contingency operations has become the norm rather than the exception, far beyond “wartime surge and backfill” role of the past. Just as the services have drawn together to become more effective and cost efficient, the AC/RC relationship has strengthened to meet the military missions.

The need for medical readiness training for all medical personnel has become a critical issue. This can be accomplished by prioritizing based on mission requirements,

not service or component. Training must become a way of life, an element of the daily mission, not a separate, once a month entity. Joint training and combined AC/RC training are essential to the success of joint missions, providing unity of focus, integration of resources, and ensuring interoperativity of care provided along the continuum of treatment. In a world where the United States is often joined by coalition partners in peacetime and humanitarian missions, the medical services participate as the United States military, not the Army, Navy, Air Force or Marines.

The Reserve Components must continue to recruit the most qualified personnel to meet the expanding missions. Smaller medical services and a decreasing number of specialists on active duty enlarges the need to have ready access to RC assets. Recruiting and retaining the essential personnel to augment active duty forces ensures the medical services will be prepared to meet any mission, anytime, anywhere.

Glossary

AC	Active Component
AMEDD	Army Medical Department
ANG	Air National Guard
ARNG	Army National Guard
BSC	Biomedical Science Corps
CONUS	Continental United States
DC	Dental Corps
HMO	Health Maintenance Organization
IMA	Individual Mobilization Augmentee
MC	Medical Corps
MMART	Mobile Medical Augmentation Readiness Team
MSC	Medical Service Corps
MTF	Medical Treatment Facility
NP	Nurse Practitioner
PA	Physician Assistant
RC	Reserve Component
USAFR	United States Air Force Reserve
USAR	United States Army Reserve
USNR	United States Naval Reserve

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